Medicaid State Plan
Incontinence Supplies (Under 21)

Incontinence Supplies are available to Medicaid eligible children under age 21 who meet established medical necessity criteria.

Providers: Incontinence supplies must be provided by licensed vendors enrolled with SCDHHS as an Incontinence Supply provider.

Covered Supplies: Medicaid state plan offers the following incontinence supplies based on medical necessity:

- One (1) case of diapers or briefs [1 case = 96 diapers or 80 briefs]
- One (1) case of incontinence pads/liners [1 case = 130 pads]
- One (1) case of underpads
- One (1) box of wipes
- One (1) box of gloves

Note: Requests for additional supplies will be considered on a case by case basis **and** if medical necessity is justified.

Criteria: The following criteria must be met for children to receive incontinence supplies:

1. The child must be between ages 4 - 20.
2. The child's inability to control bowel or bladder function must be confirmed by a Physician on the **Physician Certification of Incontinence (DHHS Form 168IS**).
3. The Service Coordinator must conduct an assessment to determine the frequency and amount of supplies authorized.

Arranging for the Service: Once the child's need has been identified and documented in the plan and in the participant's record, you will determine if the individual is eligible for incontinence supplies by having a physician complete the **Physician Certification of Incontinence (DHHS Form 168IS).** This form is to be completed annually. Upon completion of the physician certification, you must conduct a telephone assessment to determine the frequency of incontinence and the amount of supplies to be authorized. The frequency definitions are as follows:

Occasionally Incontinent =

- Bladder—Not daily. Approximately 2 or less times a week
- Bowel—Approximately once a week

Frequently Incontinent =

- Bladder—Approximately between 3 to 6 times a week, but has some control OR if the client is being toileted (w/extensive assistance) on a regular schedule.
- Bowel—Approximately between 2 to 3 times a week.

Totally Incontinent =

- No control of bladder or bowel

NOTE: If the child has an ostomy or catheter for urinary control and an ostomy for bowel control, only underpads may be authorized.

NOTE: If the individual has an appliance for bowel or bladder control, diapers may be authorized based on the frequency of incontinence.

When conducting the assessment, you should determine the number of diapers used on average/per day to calculate the number of cases of diapers and other supplies needed per month. This should be thoroughly recorded in service notes to justify the need.

Once a frequency and amount has been determined, the individual must make a choice of provider and you must complete an **Authorization for Incontinence Supplies (Form IS-3)** and send it to the provider. A copy of the authorization must remain in the individual's file. FOR INDIVIDUALS UNDER AGE 21, DO NOT ADD INCONTINENCE SUPPLIES TO THE BUDGET.

Note: An authorization for wipes is based on the presence of an incontinence need only; therefore, an individual **must also be receiving** diapers and/or underpads in order to receive wipes. Wipes cannot be authorized for cosmetic or other general hygiene purposes. They can only be authorized for the participant's incontinence care.

Monitoring Services: Because Incontinence Supplies for children is not a waiver service, you need only monitor as part of the routine "Plan Review"**.**

SCDDSN RECONSIDERATION AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability/Related Disabilities (ID/RD) Waiver, the Pervasive Developmental Disorder (PDD), the Community Supports Waiver (CSW) and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision must be sent in writing to:

State Director
SCDDSN
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process must be completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, the representative or the person assisting the participant in filing the request. If necessary, staff will assist the participant in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the participant/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the participant/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the participant/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the participant/representative fully completes the above reconsideration process and is dissatisfied with the results, the participant/representative has the right to appeal to the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The participant/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant/representative must attach a copy of the written reconsideration notification received from the SCDDSN regarding the specific matter that is the subject of the appeal. In the appeal request, the participant/representative must clearly state with specificity, which issue(s) the participant/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The participant/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
AUTHORIZATION FOR SERVICES

SC MEDICAID STATE PLAN INCONTINENCE SUPPLIES

BILL TO S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES ***(include Prior Authorization # below)***

TO: _____
Provider Name

Participant's Name: _____ **Date of Birth:** _____ **(Must be under 21 years of age)**

Address: _____
_____

Phone Number: _____ **Medicaid #:** _____

Prior Authorization # _____

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing the ID/RD Waiver. Our information indicates this person has:
☐ Medicaid only ☐ 3rd Party liability (private insurance) ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for these services.

☐ **Diapers** /each **Start Date:** _____
Number of diapers: _____ **Frequency:** ☐ Monthly ☐ Bi-Monthly ☐ Quarterly
Size: ☐ Adult Small (T4521) ☐ Adult Medium (T4522) ☐ Adult Large (T4523)
☐ Adult X-Large (T4524) ☐ Adult Bariatric (T4543)
☐ Child Small/Medium (T4529) ☐ Child Large (T4530) ☐ Youth (T4533)

☐ **Briefs (Protective Underwear)** /each **Start Date:** _____
Number of Briefs: _____ **Frequency:** ☐ Monthly ☐ Bi-Monthly ☐ Quarterly
Size: ☐ Adult Brief /Ex. Lrg (T4528) ☐ Adult Brief / Lrg (T4527) ☐ Adult Brief /Med. (T4526)
☐ Adult Brief /Sm. (T4525) ☐ Youth Brief (T4534) ☐ Child Brief Small (T4531)
☐ Child Brief Large (T4532)

☐ **Incontinence Pads (Liners)**/each (T4535) **Start Date:** _____
Number of Pads: _____ **Frequency:** ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

☐ **Under Pads**/case (A4554) **Start Date:** _____
Number of Cases: _____ **Frequency:** ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

☐ **Wipes** (T5999) **Start Date:** _____
Number of Boxes: _____ **Frequency:** ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

☐ **Gloves** (A4927) **Start Date:** _____

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Person Authorizing Services Date